EXHIBIT 2



Beth Reisch, Paralegal Paralegal Direct: (615) 252-3553 Fax: (615) 248-3015 breisch@babc.com

July 18, 2013

Matthew Cline Gideon, Cooper and Essary Suite 1100, 315 Deaderick Street Nashville, Tennessee 37238

Re: Requests for St. Thomas Hospital West Medical Records of Meningitis Claimants

Dear Mr. Cline:

Pursuant to your July 12, 2013 request for the St. Thomas Hospital West medical and billing records of 75 claimants, please find attached a listing of 30/75 claimants whose HIPAA releases are deficient. Also enclosed are the releases for each of the 30 claimants.

Please return them to their respective attorneys for completion and we will provide you with the records you are requesting.

Sincerely,

Beth Reisch, Paralegal

Beth Rusch

br

Attachment and enclosures as stated

Cc:

Amy D. Hampton Lela Hollabaugh

RECEIVED
JUL 1 9 2013

DEFICIENT RELEASES

	CLAIMANT	DEFICIENT				
1.	ALEXANDER, JOHN	No provider designated				
2.	BESAW, TRAVIS	No provider or recipient designated				
3.	BRATCHER, BEN	No provider or recipient designated. Requests psychotherapy				
		records only.				
4.	BRYANT, MARGARET	Expired release submitted without certificate of death; type of				
		records not designated				
5.	CAMPBELL, BARBARA	No provider or recipient designated. Requests psychotherapy				
		records only.				
6.	CARROLL, THERESA	No provider or recipient designated				
7.	CHAMBERS, KATHY	Incorrect provider & recipient				
8.	COLEMAN, BILLY JOE	No provider or recipient designated				
9.	EVANS, DANNY	No provider or recipient designated				
10.	FERGUSON, ROSEMARY	Undated release				
11.	GLATMAN, ELLEN	Undated release; no recipient designated				
12.	JORDAN, DORRIS	Undated release; no recipient designated				
13.	KINSEY, JOHN	Undated release; no recipient designated				
14.	LANKFORD, CHARLES	Undated release; no recipient designated				
	LOVELACE, EDDIE	Release submitted without out certificate of death				
	MARTIN, MARY NEAL	Release submitted without out certificate of death				
	MCKINNEY, JOYCE	No provider designated				
18.	MILLER, MELANIE	No provider or recipient designated. Requests psychotherapy				
		records only.				
	NASEEF, DOROTHY	No provider or recipient designated				
	PIERCE, KEN	No provider or recipient designated				
21.	PRUITT, ELIZABETH	Release submitted without out certificate of death				
22.	RAGLAND, J.W.	Release submitted without out certificate of death				
23.		Release submitted without out certificate of death				
24.	SAWYERS, JOHN	No provider designated				
	STINSON, MELAINE	No provider or recipient designated				
26.	TAYLOR, BARBARA	No provider designated				
27.	TAYLOR, BLAKE	No provider or recipient designated. Requests psychotherapy				
		records only.				
28.	TURNER, RONDAL	No provider or recipient designated				
		No provider or recipient designated				
30.	WILLIAMS, EARLINE	Release submitted without out certificate of death				

AUTHORIZATION FOR PRODUCTION OF MEDICAL DOCUMENTATION

Pursuant to TENNESSEE CODE ANNOTATED §29-26-122(a)(2)(E), I, John L. Alexander, Sr., have executed this HIPAA-compliant medical authorization that authorizes the Saint Thomas Outpatient Neurosurgical Center, LLC, and/or the designated legal representative for Saint Thomas Outpatient Neurosurgical Center, LLC, to obtain complete medical records regarding myself, John L. Alexander, Sr., Social Security Number +-9620, and date of birth (/1953.

The medical documentation which is authorized to be copied and produced to Saint Thomas Outpatient Neurosurgical Center, LLC, and/or the designated legal representative for Saint Thomas Outpatient Neurosurgical Center, LLC, would include, but not be limited to, medical records, medical reports, medical charts, X-ray reports or films, diagnostic studies, psychiatric records, psychological records. pharmacy or prescription medication records, pathology reports or slides, medical billing statements, and/or other documents, writings or tangible things related to the medical care and treatment of John L. Alexander, Sr.. The medical information that is authorized to be produced includes, but is not limited to, protected health information as defined at 45 C.F.R. 164.500, et seq., (The HIPAA Privacy Rule).

I, John L. Alexander, Sr., understand that the information in the health records may include information which is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I, John L. Alexander, Sr., understand that I have the right to revoke this authorization at any time. I, John L. Alexander, Sr., understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department and/or employment human resources or personnel department. I, John L. Alexander, Sr., understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked. this authorization will expire on the following date, or event or condition: June 28, 2020.

I, John L. Alexander, Sr., understand that authorizing the disclosure of this health information is voluntary and that I can refuse to sign this authorization. I, John L. Alexander, Sr., understand that I may inspect or copy the information to be used or disclosed, as provided by CFR 164.524. I, John L. Alexander, Sr., understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I, John L. Alexander, Sr., understand that the medical documentation and health information is being disclosed due to my claims for the severe injuries which I allege were caused when I was injected with contaminated drug products while I was under the care and treatment of Saint Thomas Outpatient Neurosurgical Center, LLC. The contaminated drug products were obtained by Saint Thomas Outpatient Neurosurgical Center, LLC from New England Compounding Pharmacy, LLC.

This health information may be disclosed to and may be used by the following organization:

Saint Thomas Outpatient Neurosurgical Center, LLC, and/or the designated legal representative for Saint Thomas Outpatient Neurosurgical Center, LLC 4230 Harding Road, Suite 901 Nashville, TN 37205 Telephone # (615) 341-3425

Date: 6/28/13

AUTHORIZATION FOR 19 IFANSE OF PROTECTED HE ALTHINFOR Section A: This section must be completed for all Authorizations Social Security No. (optional): Patieni/Plan Member Name: Birth Date: Recipient's Name: Provider's/Health Plan's Name: Addraga 1. Provider's/Health Plan's Address: Address 2: Zip: State: City: This authorization will expire on the following: (Fill in the Date or the Event but not both.) Date: April 1, 2014 Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121 Description of information to be used or disclosed Is this request for psychotherapy notes? D Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need. Date(s) Description: Date(s) Description: Date(s): Description: ALabor/delivery sum. Operative Information All PHI in medical record OB nursing assess ☐ Admission form Postpartum flow sheet Special test/therapy Dictation reports ☐ Itemized bill: ☐ Physician orders ☐ Rhythm Strips ☑ UB-92: ☑ Intake/outtake Mursing Information Other: all diagnostic D Transfer forms M Clinical Test films, x-rays, MRIs, DER Information Medication Sheets CAT scans, etc. Other: I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _______ (Initial) If not applicable, check here. □ I understand that: 1. I may refuse to sign this authorization and that it is strictly voluntary. 2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 5. I understand that I my attorney will receive copies of all records received through this authorization. 6 1' through my attorney, will get a copy of this form after I sign it. Section B: The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY IMEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization. Section C: Signatures I have read the above and authorize the disclosure of the protected health information as stated. Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: Relationship to Patient/Plan Member: Patienuplan Member's Representative:

Section A: This section must	be completed for	all Authorizations	<u> </u>				
Patieni/Plan Member Name:	tchel	Birth Date: ,	178	Social Security No	-954D		
Provider's/Health Plan's Nam	oe:	Recipient's Hame:	Recipient's Hame:				
Provider's/Health Plan's Add	Address 1: ~ ·	Address 1: ~					
		Address 2:					
		City:		State;	Zip:		
This authorization will expire Date: April 1, 2014	on the following:	(Fill in the Date or the Even Event:	t but not both.)	3		
Purpose of disclosure: CON	MPLIANCE WIT	TH T.C.A. § 29-26-121			······································		
	Des	cription of information to be	used or disclo	sed			
Is this request for psychotheral another authorization for other	oy notes? Ø Yes items below. □	, then this is the only item yo No, then you may check as r	u may reguest nany items bel	on this authorization. You n low as you need.	nust submit		
Description:	Date(s):	Description:	Date(s)	Description:	Date(s)		
☐ All PHI in medical record ☐ Admission form ☐ Dictation reports ☐ Physician orders ☐ Intake/outtake ☐ Clinical Test ☐ Medication Sheets		☐ Operative Information ☐ Cath lab ☐ Special test/therapy ☐ Rhythm Strips ☐ Nursing Information ☐ Transfer forms ☐ ER Information		☐ Labor/delivery sum. ☐ OB nursing assess ☐ Postpartum flow shed ☐ Itemized bill: ☐ UB-92: ☐ Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. ☐ Other:	et		
acknowledge, and hereby concesults or AIDS information.	sent to such, that SG. S (Initia	the released information ma	y contain alco	hol, drug abuse, psychiatric, l	HIV testing, HI		
understand that: I may refuse to sign this auth If I do not sign this form, my I may revoke this authorizati receiving the revocation. Fu If the requester or receiver is federal privacy regulations a I understand that I my attorn I, through my attorney, will	y health care and ion at any time in orther details may inot a health pland may be rediscey will receive co	the payment for my health converting, but if I do, it will not be found in the Notice of Pon or health care provider, the closed. Opies of all records received	ot have any af rivacy Practice released infor	fect.on any actions taken proess. mation may no longer be pro	or to		
ection B:		· 图:《新疆代》(1985年)《新	美人的教育				
The purpose of the relea: UTHORIZATION DOES NOT EPRESENTATIVES OUTSID fice. All medical records obtained py shall be furnished to my couns	PERMIT YOU TO E THE PRESENCE I pursuant to this a	O DISCUSS THESE MATTE. TE OF MY ATTORNEYS. You thousand the same of the same	RS WITH ANY ou may furnish t provider shall t	his law firm records that are requ be copied by their office and a B	ER OR THEIR uested by this ates-numbered		
cnon C: Signatureş							
ave read the above and author	rize the disclosur	e of the protected health infe	ormation as sta	ated.			
znature of Patient/Plan Memb	er/Guardian/Pati	endPlan Member Representa	ative:	Date: 5-20-13			
ni Name of Patient/Plan Ment	ber's Representa	ntive:		Relationship to Patient/	Plan Member:		

X

Case 1:13-md-02419-RWZ Document 925-2 Filed 02/18/14 Page 7 of 33

AUTHORIZATION FOR USE OR DISCLOSURE OF

PROTECTED HEALTH INFORMATION

Pai	ient Name:	Margar	et Rhea Bryant		Social Security Number:	<u>-7413</u>
Da	te of Birth:	<u>.</u> , .	<u>, 1938</u>		Phone Number:	931.668.4722
1. <u>The</u> infe	I authoriomas Hospita Ormation to:	ze <u>Saint T</u> al, St. Tho	homas Health Servion mas Hospitalist Grou	ces, Saint Thom pp, St. Thomas I	as Outpatient Neurosurgi Neurology Group, PLC to	cal Center, LLC, St. disclose my health
<u>Gal</u> <u>Aba</u>	<u>ligan & New</u> aray, M.D., F	. Berry H	OIT, III, Gregory B. I	antord M.D. F	7110, Christina S. Sadlo Ieritage Medical Associa	too DC ITown 11 A11
Uni	versity Medi	cal Cente	<u>., Joseph R. Zenisek.</u> r	, M.D., Steven A	A. Embry, M.D., Subir Pr	<u>asad, M.D., Vanderbil</u>
The	purpose(s) f	for the use	or disclose is as foll	owe: Litiantion		
2.	The type	and amou	int of information to	be used or discl	oced is as follows:	
	Health in	formation	covering treatment	from July 1, 201	2 to September 18, 2012	
	□ Aosua	ei (incina	s H&P, Progress No	tes,	□ Summary	•
	Proced	lure Notes	, Procedure Reports,	etc.)	□ Discharge Summa	rv (DS)
•	□ Сору о	f Medical	Records only		□ Operative/Procedu	re Report(OP)
	□ Copy o	f Comple	te Records (Medical	& Financial)	☐ Pathology Report	
	□ History	and Phys	ical (H&P)	•	□ Laboratory Report	
	Other:	lation				
 4. 	may also is alcohol ab I understanthis author named pro not apply is provides in otherwise if I fail to si I understanthis author plan, or eligabove name redisclosure have any quality signature of sig	include in Juse. Ind that I have in the depart vider has f this author in the first of the first	formation about behavior are a right to revoke must do so in writing ment. I understand to taken action in reliar corization was obtain with the right to conhis authorization will expiration date, ever horizing the disclosure he doctor or hospital or benefits on my signer to disclose my heave to disclose my heave to disclose my heave to disclosure of my bout disclosure of my heave the horizing the disclosure of my heave the disclosure of my heave the horizing the horizing the disclosure of my heave the horizing the horizing the disclosure of my heave the horizing the horizontal hor	this authorizating and present makes this authorizating and present makes are on this authorizating as a conditional test a claim under the standard conditional test are of this health may not conditionally this authorization authorization authorization authorization authorization authorization authorization.	formation relating to sexular or human immunodeficied health services, and treated on at any time. I understay written revocation to the on will not apply to the exprization. I understand the nof obtaining insurance are my policy or the policy following date, event or conthis authorization will exprise information is voluntary information is voluntary in treatment, payment, and the health information matter by certain federal print on I can contact the product.	and that, if I revoke e Health Information at my revocation will coverage and the law y itself. Unless ondition: Lican refuse to sign enrollment in its health if I authorize the may be subject to
	If signed by	Legal Rep	resentative, Relationsl	nip to Patient	•.	

Case 12124110402419-RWASE DOOR MENT 1925 12 A 15 The 01/02/18/14/10 Racyel/8 of 33 Section A: This section must be completed for all Authorizations. Patient/Plan Member Name: Social Security No. (optional): Birth Date: Provider's/Health Plan's Name. Recipient's Hame: Provider's/Health Plan's Address: Addrore to Address 2: Zip: Stage City: This authorization will expire on the following: (Fill in the Date or the Event but not both.) Date: April 1, 2014 Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121 Description of information to be used or disclosed Is this request for psychotherapy notes? Byes, then this is the only item you may request on this authorization. You must surbrait another authorization for other items below. O No, then you may check as many items below as you need. Date(s) Description: Date(s) Description: Date(s): Description: Operative Information □ Labor/delivery sum. All PHI in medical record OB nursing assess O Admission form Cath lab [] Postpartum flow sheet ☐ Special test/therapy □ Dictation reports ☐ Itemized bill: C Rhythm Strips Physician orders D UB-92: □ Intekc/ourtake O Nursing Information Other: all diagnostic Clinical Test C. Transfer forms ☐ Medication Sheets films, x-rays, MRIs, C ER Information CAT scans, etc. Other: I acknowledge, and hereby consequences to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. By (Initial) If not applicable, check here. O Lunderstand that: 1. I may refuse to sign this authorization and that it is strictly voluntary. 2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 5. I understand that I my attorney will receive copies of all records received through this authorization. 6. I, through my attorney, will get a copy of this form after I sign it. The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY IMEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [actorney and address], within five (5) days after the records are obtained through the use of this authorization. Section C: Signatures I have read the above and authorize the disclosure of the protected health information as stated. ner of Patient/Plan Member/Guardian/Patient/Plan Member Representative:

Revised 3/2003

Relationship to Patient/Plan Member:

AUTHORIZATIONF	OR TILEASE	OF PROTECTED HE	EALTH INFO	KWATION (LUT)	3				
AUTHORIZATION F Case 1.13-mo	e completed for al	Authorizations	Z FIIE0 UZ	/18/14 Page 9 0f 3	5 * * *				
Patient/Plan Member Name:	78/1	Birth Date:	149	Social Security No. (optional): 9568				
Provider's/Health Plan's Name	:	Recipient's Name:	Recipient's Name:						
Provider's/Health Plan's Addre	Address 1:~ .	Address 1:							
		Address 2:	Address 2:						
	City:		State:	Zip:					
This authorization will expire of Date: April 1, 2014	on the following: ((Fill in the Date or the Ever Event:	nt but not both.)						
Purpose of disclosure: CON	1PLIANCE WITH	HT.C.A. § 29-26-121							
·	Desc	ription of information to be	used or disclose	ėd					
Is this request for psychotherap	oy notes? 🗆 Yes, items below. 🗹	then this is the only item you	ou may request o many items belo	on this authorization. You mu was you need.					
Description:	Date(s): .	Description:	Date(s)	Description:	Date(s)				
All PHI in medical record O Admission form O Dictation reports O Physician orders Intake/outtake O Clinical Test Medication Sheets		☐ Operative Information ☐ Cath lab ☐ Special test/therapy ☐ Rhythm Strips ☐ Nursing Information ☐ Transfer forms ☐ ER Information		☐ Labor/delivery sum. ☐ OB nursing assess ☐ Postpartum flow sheet ☐ Itemized bill: ☐ UB-92: ☐ Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. ☐ Other:					
l acknowledge, and hereby con results or AIDS information.	isent to such, that	the released information mathematics in the released information mathematics in the second second in the second second in the second se	nay contain alcoh here. []	nol, drug abuse, psychiatric, H	IV testing, HIV				
1 understand that: 1. I may refuse to sign this aut 2. If I do not sign this form, m 3. I may revoke this authorizat receiving the revocation. F 4. If the requester or receiver i federal privacy regulations 5. I understand that I my attor 6. I, through my attorney, will	horization and the y health care and the care and tion at any time in urther details may so not a health play and may be rediscusting the care will receive to the care will receive the care and the	at it is strictly voluntary. the payment for my health n writing, but if I do, it will y be found in the Notice of n or health care provider, the closed. Topies of all records receive	care will not be not have any aff Privacy Practice he released infor	rs. mation may no longer be prot					
Section B:					THE				
The purpose of the relection DOES NOT REPRESENTATIVES OUTSIE office. All medical records obtains copy shall be furnished to my cour	PERMIT YOU I DE THE PRESEN	CE OF MY ATTORNEYS.	You may furnish t	be conied by their office and a Ba	ested by this ites-numbered				
Section C: Signatures					4				
I have read the above and auth				1					
Singsturf of Patient/Plan Mem	ber/Guardian/Pal	tient/Plan Member Represe	entative:	Date: 5/19/13	21a - March				
Print Name of Patient/Plan Me There Sa	thber's Represent	Parive: Carro 11 Kobe	Harry	Relationship to Patient	rian Memoer:				

<u>AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)</u> Saction A: This section must be completed for all Authorizations Birth Date: Resign VR is a Morabor Name: Kathy J. Chambers Social Security No.: 415-88-9081 Persons or Organizations Authorized to Disclose the Information: Persons or Organizations Authorized to Receive the Information: Howell Allen Clinic a Professional Corporation Saint Thomas Outpatient Neurosurgical Center, LLC This authorization will expire on the following: (Fill in the Date or the Event but not both.) Dato: 04/20/14 Event: Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-12 Description of information to be used or disclosed Is this request for psychotherapy notes? 🗆 Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below.

No, then you may check as many items below as you need. Description: Datc(s): Description: Date(s) Description: Date(s) X Operative Information X All PHI in medical record D Labor/delivery sum. X Admission form X Cath lab □ OB nursing assess X Dictation reports X Special test/therapy □ Postpartum flow sheet X Physician orders X Rhythm Strips X Itemized bill: X Intake/outtake X Nursing Information X UB-92: X Transfer forms X Clinical Test X Other: all diagnostic X Medication Sheets X ER Information films, x-rays, MRIs, CAT scans, etc. n Other: I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. 🤸 (Initial) If not applicable, check here. I understand that: 1. I may refuse to sign this authorization and that it is strictly voluntary. 2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 5. I understand that I my attorney will receive copies of all records received through this authorization. 6. I, through my attorney, will get a copy of this form after I sign it. 7. A photostatic copy of this Authorization is to be considered as effective as the original. Section B: THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L, Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization. Section C: Signatures I have read the above and authorize the disclosure of the protected health information as stated. Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: Relationship to Patient/Plan Member:

hambers

Case 1:13-md-02419-RWZ Document 925-2 Filed 02/18/14 Page 11 of 33
AUTHORIZATION FOR TLEASE OF PROTECTED HEALTH INFORMATION (PHI)

AUTHORIZATION F				WILL WILLOW	Treve (AV			
Section A: This section must be	e completed for al	l Autho			Social Security No.	Inntinanh-		
Patien/Plan Member Name:	deman		Birth Da	59	1 -	32 <u>73</u>		
Provider's/Health Plan's Name	a second		Recipient's Name:		•			
Provider's/Health Plan's Addre	:55:		Address 1					
·	•		Address 2:	Address 2:				
	·		City		States	Zip: . ·		
This authorization will expire of Date: April 1, 2014	on the following: ((Fil) in	the Date or the Event Event:	but not both.)				
Purpose of disclosure: CON	ipliance with	4 T.C.A	§ 29-26-121					
			of information to be					
Is this request for psychotherap another authorization for other	oy notes? [] Yes, items below. []	then th No. the	is is the only item you n you may check as n	i may request on t any items below	his authorization. You make you need.	ust submit		
Description:	Date(s):	Ĺ	ription:	Darc(s)	Description:	Date(s)		
All PHI in medical record Admission form Distance information D								
l auknowledge, and hereby cor results or AIDS information. I understand that: 1. I may refuse to sign this aut 2. If I do not sign this form, in 3. I may revoke this authorizate receiving the revocation.	thorization and the	at it is: I the pay	strictly voluntary. yment for my health o	are will not be aff	ected unless stated other ton any actions taken pri	vise. or to		
receiving the revocation. F 4. If the requester or receiver is federal privacy regulations 5. I understand that I my attor 6. I, through my attorney, will	is not a health pla and may be redis nev will receive o	in or he closed. copies e	alth care provider, the of all records received	s Édicazén miorne		otected by		
Section B:	<i>y</i> • • • • • • • • • • • • • • • • • • •	• • •	企业的建筑级					
The purpose of the relative to	PERMIT YOU DE THE PRESEN	CE OF	MY ATTORNEYS. Y	ou may furnish this	conied by their office and a	quested by this Bates-numbered		
Section C: Signatures	· , · · ·		Paris de la company	A STANKE				
I have read the above and suth	orize the discloss	ure of ti	he protected health in	formation as state	d.			
		-	an Member Represen)		Dale: 5/20/13	and the second of the second o		
Princhlame of Editair Plany Man	chiber's Represen	tative:			Relationship to Patien	u/Plan Member:		
Levised 3/2003	***********)	•		

Patient/Plan Mcmber Name:	(a.c.	A Committee of the Comm	Birth Date.	704	Social Security	y No. (op _18	ntional): Q3	
DAMY EVA	715		101 -1000					
Provider's/Health'Plan's Nam	e:	endrite sanglenden	Recipient's Name:					
Provider's/Health Plan's Addr	ess:		-Address.1				-	
			Address 2:					
			City:		State:	Zi	p:	
This authorization will expire Date: April 1, 2014	on the following:		he Date or the Event Event:	but not both.)				
Purpose of disclosure: COM	MPLIANCE WITH	Н Т.С.А.	§ 29-26-121					
*	Desc	cription c	of information to be	used or disclosed				
Is this request for psychotherap another authorization for other	py notes? D Yes, items below. D	then this No, then	s is the only item you	u may request on nany items below	this authorization. Y	ou must s	submit	
Description:	Date(s):	Descri	otion:	Date(s)	Description:		Date(s)	
All PHI in medical record Admission form Dictation reports Physician orders Intake/outtake Clinical Test Medication Sheets	nission form Lation reports sician orders ke/outtake lical Test		rative Information a lab cial test/therapy thm Strips sing Information asfer forms Information		Di.abor/delivery's OB nursing asse Postpartum flow Itemized bill: UB-92: Other: all diagno films, x-rays, Mi CAT scans, etc. Other:	ss sheet ostic	·	
acknowledge, and hereby concesults or AIDS information.	sent to such, that DFE (Initia	the relea al) If not	sed information ma applicable, check h	y contain alcohol iere. []	, drug abuse, psychia	tric, HIV	testing, HIV	
understand that: I may refuse to sign this aution. If I do not sign this form, may revoke this authorizat receiving the revocation. Further requester or receiver in federal privacy regulations at I understand that I my attorn. I, through my attorney, will	y health care and ion at any time in urther details may s not a health plar and may be redisc tey will receive co	the paym writing, be found or healt losed. opies of a	nent for my health count if I do, it will not in the Notice of Poth care provider, the all records received	ot have any anectivacy Practices. released informa	ition may no longer b	, prior to	ed by	
ection B:							* 1	
The purpose of the releasuTHORIZATION DOES NOT EPRESENTATIVES OUTSID Tice. All medical records obtaine py shall be furnished to my countries.	PERMIT YOU TO E THE PRESENCE d pursuant to this a	O DISCU JE OF M whorizati	SS THESE MATTE Y ATTORNEYS. '' on by Imedical case i	RS WITH ANY IN ou may furnish this provider! shall be c	law firm records that ar opied by their office an	e requeste d a Bates-	d by this numbered	
ection C: Signatureş		7.7						
nave read the above and autho	rize the disclosur	e of the p	protected health inf	ormation as stated	3.			
anature of PatienyPtan Memb	ocr/Guardian/Pati	ent/Plan	Member Represent	ative:	Date: 5/22/13			
10 h	1				la miliania par	iant/Dlan	Mamban	

Case 1:13-md-02419-RWZ DOCTOPENT DESCRIPTION FOR LEASE OF PROTECTED HEALTH INFORM ATION (FILE) 133

Section A: This section must	be completed fo	rall Auth	orizations	7. 3 G. 4 180.	7 1. 186			
Patient/Plan Member Name:		······································	Birth Date:	Birth Date: Social Security No			o. (c	pptional):
Rosemary C. Ferguson	1	,	956				,18	
Provider's/Health Plan's Nam St. Thomas Hospital	ie:		Recipient's Name:					
Provider's/Health Plan's Add	resst		Addrese I.				-	· · · · · · · · · · · · · · · · · · ·
4220 Harding Road Nashville, TN 37205			Address 2:					
,			City:			State:	Z	lip:
This authorization will expire Date: April 1, 2014	on the followin	g: (Fill in	the Date or the Even Event:	t but not both.)			i.	•
Purpose of disclosure: CO	MPLIANCE WI	тн т.с.	. § 29-26-121					•
	Ď	escription	of information to be	used or disclos	sèd			
Is this request for psychothera another authorization for other	ov notes? (1) Ye	s then th	is is the only item yo	u may request	on this a	uthorization. You u need,	must	submit
Description:	Date(s):	1	iption:	Date(s)		cription:		Date(s)
All PHI in medical record Admission form Dictation reports Physician orders Intake/outtake Clinical Test Medication Sheets		C/Ca C/Sp C/Rh M/No C/Fra	erative Information th lab ceial test/therapy ythm Strips rsing Information master forms Information			abor/delivery sum DB nursing assess postpartum flow sh temized bill: 18-92: Other, all diagnosti lins, x-rays, MRIs AT scans, etc.	eet	
l acknowledge, and hereby con results or AIDS information.	sent to such, th	at the rele	ased information ma et applicable, check i	y contain alcoh rere. []	ol, drug	abuse, psychiatric	, HIV	testing, HIV
I understand that: 1. I may refuse to sign this auti 2. If I do not sign this form, m 3. I may revoke this authorizat receiving the revocation: Ft 4. If the requester or receiver is federal privacy regulations a 5. I understand that I my attom 5. I, through my attorney, will section B:	y health care an ion at any time orther details ma onot a health pl nd may be redi ey will receive	d the paying writing ay be four lan or hea sclosed. copies of	ment for my health c	ot have any arr rivacy Practices released infor	s. mation m	ay no longer be pr	ior to	
The purpose of the releasure of the rele	PERMIT YOU E THE PRESEN	CE OF M	ISS THESE MATTE IV ATTORNEYS. You	ou may furnish th	nis law fin c copied b	m records that are re-	questo Bates-	d by this numbered
ection C: Signatures			Recorded to	NALL WILL	Targetters			
have read the above and author	rize the disclosi	ure of the	protected health info	ormation as stat	ted.			
ianature of Stien/Plan Memb		ticn/Plan	Member Representa	ative:	Date			
rint Name of Patient/Plan Men	iber's Represen	tative:	Robert L	buna	Rela	tionship to Patient	/Plan	Member:
evised 3/2003			4	× «		7		

C - 4

CAUTHORIZATION	FORKWEAS	FOFE	COLECTED HE	APT APT SE	1 111	Sign Africa	22	
Section A: This section must								
Patient/Plan Member Name:			Birth Date:			Social Security	/No. (optional):
Ellen Glatman			1960				-	
Provider's/Health Plan's Nam St. Thomas Hospital	ne:	- 1	Recipient's Name:					
Provider's/Health Plan's Add	ress:	F	Ta delsore 1-					
4220 Harding Road Nashville, TN 37205			Address 2:					
			City:	•		State:		Zip:
This authorization will expire Date: April 1, 2014	on the following:	(Fill in the	Date or the Even	t but not both.)				•
Purpose of disclosure: CO	MPLIANCE WIT	H T.C.A. (29-26-121	•				·
* *	Desc	cription of	information to be	used or disclosed	1		, , , , , , , , , , , , , , , , , , , 	and the second seco
Is this request for psychothera another authorization for other	py notes? DYes, items below. Ø	then this No, then y	is the only item you	u may request on nany items below	this a	uthorization. You need.	วน ภาบร	t submit
Description:	Date(s):	Descript	ion:	Date(s)	De.	seription:		Date(s)
All PHI in medical record Admission form Dictation reports Physician orders Intake/outtake Clinical Test Medication Sheets		Cath Special S	al test/therapy			abor/delivery supported by the state of the	sheet stic	
acknowledge, and hereby concessults or AIDS information.	sent to such, that	the released	ed information ma pplicable, check h	y contain alcoho ere. 🖸	l, drug	abuse, psychiau	ric, HIV	testing, HIV
understand that: I may refuse to sign this auth If I do not sign this form, my I may revoke this authorizative receiver, the revocation. Fit is requester or receiver is federal privacy regulations a I understand that I my attorn I, through my attorney, will	y health care and ion at any time in inther details may snot a health plan and may be rediseley will receive co	the payme writing, b be found or health losed. pries of all	nt for my health ca out if I do, it will no in the Notice of Pr care provider, the records received	ot have any anec ivacy Practices. released inform	r.on a	nay no longer be	prior ic	
ection B:				ELECTION 1944	Q-(Y	MINERAL COLUMN		
The purpose of the releas UTHORIZATION DOES NOT EPRESENTATIVES OUTSIDE fice. All medical records obtained ply shall be furnished to my couns	PERMIT YOUTO E THE PRESENC	E OF MY	ATTORNEYS. You have medical care of	nu may furnish this provider! shall be o	law fir	m records that are by their office and	request a Bates	ed by this
cnon C: Signatureş			The state of the s			98517 F18. WY	rit, ji	
nave read the above and author	rize the disclosure	e of the pr	otected health info	ormation as stated] .			
anature of Stient/Plan Memb	er/Guardian/Patie	nvPlan M	lember Representa	uive:	Date			A
int Name of Palient/Plan Merh	ber's Representa	tive: 🕡	boul 11	(Rela	tionship to Patie	nvPlai	n Member:

COSCIONATION FOR PAYEASE OF PROTECTED HENE OF WARRING UNITED 133 Section A: This section must be completed for all Authorizations Social Security No. (optional): Birth Date: Patient/Plan Member Name: **Dorris Jordan** /1957 Recipient's Name: Provider's/Health Plan's Name: St. Thomas Hospital Address 12 -- . Provider's/Health Plan's Address: 4220 Harding Road Address 2: Nashville, TN 37205 Zipa State: City: This authorization will expire on the following: (Fill in the Date or the Event but not both.) Date: April 1, 2014 COMPLIANCE WITH T.C.A. § 29-26-121 Purpose of disclosure: Description of information to be used or disclosed Is this request for psychotherapy notes? Dyes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need. Description: Date(s) Description: Date(s): Description: (Labor/delivery sum. Operative Information All PHI in medical record DOB nursing assess Cath lab O'Admission form Departum flow sheet Special test/therapy Dictation reports Oftemized bill: (2) Rhythm Strips Physician orders ₩¥.92: M Nursing Information Intake/outtake Other, all diagnostic W Transfer forms Clinical Test films, x-rays, MRIs, Medication Sheets DER Information CAT scans, etc. Other: I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. [17] (Initial) If not applicable, check here. [1] I understand that: 1. I may refuse to sign this authorization and that it is strictly voluntary. 2. If I do not sign this form, my health care and the payment for my health cate will not be affected unless stated otherwise. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation: Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 5. I understand that I my attorney will receive copies of all records received through this authorization. 6. I, through my attorney, will get a copy of this form after I sign it, THE REPORT OF THE PROPERTY OF Section B: The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY IMEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES! OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Office. All medical records obtained physical to this authorization.

Copy shall be furnished to my counsel factorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protested health information as stated.

Signature of Section!/Plan Member/Guardian/Patient/Plan Member Representative:

Date:

Print Name of Pasient/Plan Member's Representative: ADUTA

Relationship to Patient/Plan Member: Https://doi.org/10.1001/10.10

COSSIGNATION AND REVEASE OF UPROTECTED AND INTERPORTED AND A FROM (PRO) of 33 Section A: This section must be completed for all Authorizations Social Security No. (optional): Patien/Plan Member Name: Birth Date: /1962 John Kinsey Provider's/Health Plan's Name: Recipient's Name: St. Thomas Hospital Address Is - . Provider's/Health Plan's Address: 4220 Harding Road Address 2: Nashville, TN 37205 Zip: State: City: This authorization will expire on the following: (Fill in the Date or the Event but not both.) Date: April 1, 2014 Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121 Description of information to be used or disclosed Is this request for psychotherapy notes?

Yes, then this is the only item you may request on this authorization. You must submit ariother authorization for other items below. INo, then you may check as many items below as you need. Date(s) Description: Date(s) Description: Description: Date(s): Mabor/delivery sum. Operative Information All PHI in medical record DOB nursing assess D'Admission form Cath lab Postpartum flow sheet Special test/therapy Dictation reports Memized bill: Rhythm Strips Physician orders ₩ UB-92: Mursing Information ☑ Intake/outtake Other, all diagnostic W Fransfer forms Clinical Test films, x-rays, MRIs, ER Information Medication Sheets CAT scans, etc. Other: I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. [17] (Initial) If not applicable, check here. [1] I understand that: 1. I may refuse to sign this authorization and that it is strictly voluntary. 2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 5. I understand that I my attorney will receive copies of all records received through this authorization. 6. I, through my attorney, will get a copy of this form after I sign it, The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY IMEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization. TO A THE PERSON OF THE PERSON Section C: Signatures I have read the above and authorize the disclosure of the protected health information as stated.

Revised 3/2003

Sianahire of Estian Valan Member/Guardian/Patien VPlan Member Representative:

Print Name of Patient/Plan Member's Representative: RODERT

Date: _-

Relationship to Patient/Plan Member:

CALEHORIZATION							33	
Section A: This section must	be completed for a	ill Auth	ofizations"	<u> </u>	134	1 '		
Patien/Plan Member Name: Charles Lankford			Birth Date: // 93	7		Social Security	No. (optional):
Provider's/Health Plan's Nam St. Thomas Hospital	e:		Recipient's Name:					
Provider's/Health Plan's Add	ress:		Addrove b.					
4220 Harding Road Nashville, TN 37205			Address 2:					
			City:	<u>-</u>		State:		Zip:
This authorization will expire Date: April 1, 2014	on the following:		the Date or the Even Event:	t but not both.)				
Purpose of disclosure: CO	MPLIANCE WITH	H T.C.A	. § 29-26-121					
•	Desc	ription	of information to be	used or disclos	èd			
Is this request for psychotheral another authorization for other	py notes? DYes, items below. Ø	then thi	s is the only item yo I you may check as i	u may request o	on this a	uthorization. You need.	u mus	t submit
Description:	Date(s):	Descri	ption:	Date(s)	De	scription:		Date(s)
All PHI in medical record Admission form Dictation reports Physician orders Intake/outtake Clinical Test Medication Sheets		Cat Co Spe Co Rhy M Nur Co Fra	trative Information h lab cial test/therapy thm Strips sing Information nsfer forms Information		10 10 10 10 10 10 10 10 10 10 10 10 10 1	abor/delivery sur OB nursing assess Postpartum flow s Itemized bill: UB-92: Other: all diagnos illms, x-rays, MR CAT scans, etc.	sheet tic	
acknowledge, and hereby concesults or AIDS information.	sent to such, that	the relea	ased information ma t applicable, check h	y contain alcoh ere. 🗆		Other: ; abuse, psychiatri	ic, HI	V testing, HIV
understand that: I may refuse to sign this aution of the lift of the requester or receiver is federal privacy regulations at lunderstand that I my attorn, I, through my attorney, will	y health care and to ton at any time in orther details may snot a health plan and may be rediscley will receive co get a copy of this	writing be foun or heal osed, pies of	nent for my health or but if I do; it will n d in the Notice of Pr th care provider, the all records received	ot have any and ivacy Practices released infor	et on a nation r	ny actions taken t	onor t	0
ection B:				Reaching in:	M2717		***	
The purpose of the releas UTHORIZATION DOES NOT EPRESENTATIVES OUTSIDE fice. All medical records obtained py shall be furnished to my couns	PERMIT YOU TO E THE PRESENC	DISCU E OF M thorizati	SS THESE MATTEL Y ATTORNEYS. You on by Imedical care of	ns WITH ANY no may furnish the roylderl shall be	is law fin copied	m records that are in by their office and in	eques Bate	ted by this s-numbered
ction C: Signatures		•			(MC)		4.0	
ave read the above and author	rize the disclosure	of the	protected health info	rmation as stat	ed.			
anature of Potent/Blan Memb		nVPlan	Member Representa	itive:	Date		منمستسد	
nt Name of Patient/Plan Med		iive: K	obert U	buna	Rek	pionship to Paties	nv∕Pla	n Member.
vised 3/2003	Śwaria, po do do					1	1	

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PMT) Section A: This section must be completed for all Authorizations Social Security No.: 1-4889 Birth Dates)/34 Patient/Plan Member Name: Eddie C. Lovelace Persons or Organizations Authorized to Receive the Information: Persons or Organizations Authorized to Disclose the Information; Saint Thomas Outpatient Neurosurgical Center, LLC St. Thomas Hospital Saint Thomas Network Saint Thomas Health Saint Thomas Medical Clinic This authorization will expire on the following: (Fill in the Date or the Event but not both.) Event: Date: 04/20/14 COMPLIANCE WITH T.C.A. § 29-26-121 Purpose of displosure: Description of information to befused or disclosed Is this request for psychotherapy notes? In Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below, 13 No, then you may check as many items below as you need. Date(s) Description: Date(a) Dato(s). Description: Description: a Labor/delivery sum. X Operative Information X All PHI in medical record r OB nursing assess X Cath lab X Admission form r) Postpartum flow shoot X Special test/therapy X Dietation reports X Itemized hill: X Rhythm Strips X Physician orders X UB-92: X Nursing Information X Intake/outtake X Other; all diagnostic X Transfer forms X Clinical Test films, x-rays, MRIs. X ER Information X Medication Sheets CAT scans, etc. D Other: Lacknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV texting, HIV results of AIDS information. (Initial) If not applicable, check here. I understand that: 1. I may reliuse to sign this authorization and that it is strictly voluntary. 2. If I do not sign this form, my health care and the payment for my health ours will not be affected unless stated otherwise. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 5. I understand that I my attorney will receive copies of all records received through this authorization. 6. I, through my automey, will ger a copy of this form after I sign it. 7. A photostatic copy of this Authorization is to be considered as effective as the original. Section B: THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed cutifies shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L, Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Bonlevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization. Section CuSignatures I have read the above and authorize the disclosure of the protected health information as stated. Signature of Parion/Plan Member/Guardian/Patien/Plan Member Representative: 03/21/2013 Relationship to Patient/Plan Member: Print Name of Patient/Plan Member's Representative:

Joyce J. Lovelince

LIMITED AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION OR RECORDS

By signing below, I hereby request and authorize the Health Care Provider identified below to disclose certain information (the "Information") as provided in this Authorization.
Information To Be Used Or Disclosed
Patient Name: Mary Neal Martin Patient Identifier: DOB: 1923
Description of Information: Any and all medical information and records, or true and correct copies thereof, in your possession, custody or control, including, but not limited to, medical histories, records, reports, summaries, diagnosis, prognoses, records of treatment and medication ordered and/or given, entries, letters or correspondence to other physicians, electrocardiograms, x-ray films and reports, ultrasounds, diagnostic imaging studies, laboratory data and records, pathological reports, slides and specimens, prescription records, insurance records, bills or statements of account, incident reports, birth certificates, death certificates and all other written or graphic data prepared, kept, made or maintained in your possession, custody or control and summaries of injuries, treatment and prognosis, if requested, that pertain to the Patient. THIS AUTHORIZATION DOES NOT AUTHORIZE VERBAL COMMUNICATIONS WITH THE REFERENCED INDIVIDUAL OR ORGANIZATION.
Persons Or Organizations Authorized To Disclose The Information
Health Care Provider: Saint Thomas Outpatient Neurosurgical Center, LLC; Howell Allen Clinic A Professional Corporation; St. Thomas Hospital; John Weeks Culclasure, M.D.; Debra V. Schamberg, R.N.
I authorize the Health Care Provider(s) and its employees and agents to disclose the Information as provided in this Authorization. A photostatic copy of this Authorization is to be considered as effective as the original. I understand that I am not required to sign this Authorization. The Health Care Provider will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization.
Persons or Organizations Authorized to Receive the Information
Howell Allen Clinic A Professional Corporation or any representative, attorney or investigator from said organization, c/o Gregory B. Lanford, M.D., 2011 Murphy Ave, Ste 301, Nashville, TN 37203-2023.
Purpose of the Requested Use or Disclosure
At the varpoest of the undersigned
Expiration and Revocation of This Authorization
Expiration Date or Event: 10 130 2013
I understand that I may revoke this Authorization at any time prior to the expiration date or event, but that my revocation will not have any affect on actions taken by the Health Care Provider, its employees or agents before they received my revocation. Should I desire to revoke this Authorization, I must send written notice to the Health Care Provider at the following address:
I understand that I may see and copy the Information if I ask/for it. I understand that any Information released may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy law br regulations. The provided HTML is a subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy law br regulations.
Signature (Patient) Date Signature (Authorized Representative) Date Output Date
Signature (Witness) Relationship to Pátieht
Ophatalo (1750000)

Jun. 14. 2013 7.42AM Case 1:13-md-02419-RWZ Document PAS 2.2 Filed 02/18/14 Page 20 of 33 AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHD)

Joyce P. McKinney		Birth Date:	- 1939		Social Security No.	
Provider's/Health Plan's	Name & Address:	Recipient's Name		Dr. John W. Culclasure		
<i>(</i>	ا ما	Address I:			utpatient Neuro Center	surgical —
See Alto	ماري ماري	Address 2:	423	4230 Harding Road, Ste. 901 Nashville, TN 37205		
		City:			State;	Zip:
This authorization will ex Date:	opire on the following Event:	g: (Fill in the Date or the Eve Conclusion of Litigation	nt but not both.)			
Purpose of disclosure:	COMPLIANCE WI	TH T.C.A. § 29-26-121				
	D	escription of information to b	e used or disclos	ed		
Is this request for psycho another authorization for	therapy notes? Yother items below.	es, then this is the only item y K No, then you may check as	ou may request many items belo	on this a	uthorization. You :	must submit
Description:	Date(s):	Description:	Date(s)		cription:	Date(s)
X Admission form X Dictation reports X Physician orders X Intake/outtake X Clinical Test X Medication Sheets		X Cath lab X Special test/therapy X Rhythm Strips X Nursing Information X Transfer forms X ER Information		XP XI X C fi	OB nursing assess to stpartum flow she temized bill: JB-92: Other: all diagnostic lims, x-rays, MRIs, CAT scans, etc. Other:	
I acknowledge, and heret results or AIDS informati	oy consent to such, thion(Ini	at the released information mittal) If not applicable, check	ay contain alcoh here. 🗆	ol, drug	abuse, psychiatric,	HIV testing, I
 I may revoke this authority Further details may be found 	my health care and the zation at any time in wr if in the Notice of Privaçer is not a health plan or sclosed, orney will receive copicial get a copy of this for	payment for my health care will iting, but if I do, it will not have by Practices. health care provider, the release so of all records received through an after I sign it.	any affect on any a d information may	actions tal no longe	ken prior to receiving	
5. I understand that I my att 6. I, through my attorney, w						
regulations and may be redis 5. I understand that I my att 6. I, through my attorney, w Section B:						
regulations and may be reduced to the following state of the following state of the purpose of the release	e. of my: records; is: for.	review by the above name		_		
regulations and may be redis 5. I understand that I my att 6. I, through my attorney, w Section B: The: purpose of the release THIS AUTHORIZATION De	e.of.myrecords; is:for. OES NOT PERMIT YO	review by: 	TERS WITH ANY	, IŴEDIC	AL CARE PROVIDE	R OR THEIR
regulations and may be redis 5. I understand that I my att 6. I, through my attorney, w Section B: The: purpose of the release THIS AUTHORIZATION DE REPRESENTATIVES OUT	e of my:records; is:for OES <i>NOT</i> PERMIT YOU ISIDE THE PRESENC	review by the element DU TO DISCUSS THESE MAT E OF MY ATTORNEYS. You	TERS WITH ANY	aw fitw	AL CARE PROVIDE	R OR THEIR
THIS AUTHORIZATION DO REPRESENTATIVES OUT Office. All medical records	e.of.myrecords; is.:for. OES NOT PERMIT YOU ISIDE THE PRESENC obtained pursuant to	review by the store name of the second of th	TERS WITH ANY may furnish this	MEDIC law firm	AL CARE PROVIDE records that are required by	R OR THEIR Jested by this of their office ar
Section B: The: purpose of the release THIS AUTHORIZATION DO REPRESENTATIVES OUT office. All medical records Bates-numbered copy shall	e. of my: records; is: for OES NOT PERMIT YOU ISIDE THE PRESENC obtained pursuant to I be furnished to my o	review by the element DU TO DISCUSS THESE MAT E OF MY ATTORNEYS. You	TERS WITH ANY may furnish this out named Router, Vines & Ba	MEDIC law firm	AL CARE PROVIDE records that are required by	R OR THEIR Jested by this of their office ar
segulations and may be redis 5. I understand that I my att 6. I, through my attorney, w Section B: The: purpose of the release THIS AUTHORIZATION DO REPRESENTATIVES OUT office. All medical records Bates-numbered copy shall 37919, within five (5) days	e. of my: records; is: for OES NOT PERMIT YOU SIDE THE PRESENCE obtained pursuant to I be furnished to my os after the records are	review by ** ** ** ** ** ** ** ** ** ** ** ** **	may furnish this may furnish this man and the utler, Vines & Banis authorization.	IMEDIC law firm Copic labb, PLLC	AL CARE PROVIDE records that are required by	R OR THEIR Jested by this of their office ar
regulations and may be redis 5. I understand that I my att 6. I, through my attorney, w Section B: The: purpose of the release THIS AUTHORIZATION DO REPRESENTATIVES OUT office. All medical records Bates-numbered copy shal 37919, within five (5) days Section C Signatures	e of my: records; is for OES NOT PERMIT YOU IS IDE THE PRESENCE obtained pursuant to I be furnished to my one after the records are	review by He always named by TO DISCUSS THESE MAT BE OF MY ATTORNEYS. You this authorization by He always ounsel William D. Vines, III, B obtained through the use of the second	may furnish this come named (c) utler, Vines & Banis authorization.	IMEDIC law firm Lapad labb, PLL(AL CARE PROVIDE records that are required by	R OR THEIR Jested by this of their office ar
regulations and may be redis 5. I understand that I my att 6. I, through my attorney, w Section B: The: purpose of the release THIS AUTHORIZATION DO REPRESENTATIVES OUT office. All medical records Bates-numbered copy shall 37919, within five (5) days Section C Signatures I have read the above and	e of my records; is for OES NOT PERMIT YOU IS THE PRESENCE obtained pursuant to I be furnished to my one after the records are authorize the discloss.	review by ** ** ** ** ** ** ** ** ** ** ** ** **	may furnish this cold named R utler, Vines & Banis authorization.	IMEDIC law firm Lapad labb, PLL(AL CARE PROVIDE records that are requestions shall be copied by C, 2701 Kingston Pi	R OR THEIR Jested by this of their office ar
regulations and may be redis 5. I understand that I my att 6. I, through my attorney, w Section B: The: purpose of the release THIS AUTHORIZATION DO REPRESENTATIVES OUT office. All medical records Bates-numbered copy shall 37919, within five (5) days Section C Signatures I have read the above and	e of my records; is for OES NOT PERMIT YOU ISIDE THE PRESENCE obtained pursuant to I be furnished to my obtained the records are authorize the disclosure of	review by ATORNEYS. You this authorization by 11-26 oursel William D. Vines, III, B obtained through the use of the protected health-in attent/Plan Member Representation.	may furnish this cold named R utler, Vines & Banis authorization.	IMEDIC law firm Lapic A labb, PLLO	AL CARE PROVIDE records that are requestions shall be copied by C, 2701 Kingston Pi	R OR THEIR Juested by this If their office ar If their office a

Case 1:13-md-02419-RWZ Document 925-2 Filed 02/18/14 Page 21 of 33

AUTHORIZATION		PROTECTED ME	TAPIDIMENT	WATACH TANK	
Section A: This section must be	se compreted for all Aut	hodznijana			
Patient/Plan Member Name:	nilled	Birth Date:	/77	Social Security No.	(optional): 1
Provider's/Health Plan's Norm		Recipient's Hame:	-		
Provider's/Health Plan's Addr	'ess:	Address 1:			
	. ,	Address 2:			
	Authorit d. HTTPR. d	City:		States	Zip:
This authorization will expire of Date: April 1, 2014	nn the following: (Fill i	n the Date or the Even Events	t but not both.)		
Purpose of disclosure: CON	APLIANCE WITH T.C.	.A. § 29-26-121		A CONTRACTOR OF THE PROPERTY O	
THE RESERVE TO SERVE THE PROPERTY OF THE PROPE	Descriptio	n of information to be	used or disclosed		· · · · · · · · · · · · · · · · · · ·
Is this request for psychotherap another authorization for other	y notes? Wyes, then the ltems below. DNo, the	this is the only item you	u may request on the	his authorization. You nu as you need.	ust submit
Descriptions	Date(s): Desc	cription:	'Dayo(s)	Descriptioni	Dutc(s)
☐ All PHI in medical record ☐ Admission form ☐ Dictation reports ☐ Physician orders ☐ Intake/outtake ☐ Clinical Test ☐ Medication Sheets	0 C C C C C C C C C C C C C C C C C C C	Operative Information Cath lab Special teat/thorapy Chythm Strips Lucking Information Transfer forms IR Information		☐ Labor/delivery sum. ☐ OB nursing assess ☐ Postpaytum flow sheet ☐ itemized bill: ☐ UB-92: ☐ Others all diagnostic films, x-rays, MRIz, ☐ CAT scans, etc. ☐ Others	
i xcknowledge, and hereby consequity or AIDS information.	sent to such, that the re	leased information mands applicable, check i	ty contain alcohol,	drug abuse, psychiatric, H	IIV testing, HIV
t understand that: 1. I may refuse to sign this auth 2. If I do not sign this form, my 3. I may revoke this authorization 4. If the requester or receiver is 5. If the requester or receiver is 6. I understand that I my attorn 6. I, through my attorney, will a	y health care and the pa ion at any time in writin irther dotalls may be for s not a health plan or he and may be rediselosed. tey will receive copies o	nyment for my health c ng, but if I do, it will r und in the Notice of P calth care provider, the of all records received	not have any ancer. Privacy Practices. e released informati	tion may no longer be prot	
icetion B		,我们就是是我的	对描述数据的 中的	<u>ATTEMEDIALETETT</u>	
The purpose of the releas. LITHORIZATION DOES NOT. EPPESENTATIVES OUTSIDE files. All oxedical resords obtained topy shall be furnished to my course.	PERMIT YOU TO DISC E THE PRESENCE OF A DUSTUMENT TO THIS RUBBURIZ	CUSS THESE MATTE MY ATTORNEYS. Y	Ou may furnish this li nepylderl shall be 60	opied by their office and a figh	icated by this
cotion C: Signatures	11,1				April 1
have read the above and author	rize the disclosure of th	ne protected health in	formation as stated.		
ionature of Patient/Plan Memb				Date: 5/28/13	
rint Name of Patient/Plan Med	hber's Representative	+ /171,000		Relationship to PatienUP	lan Member.

AUTIORIZATION FOR • LEASE OF PROTECTED HEALTH INFORMATION Section A: This section must be compreted for all Authorizations Birth Date: Sacial Semily No. (collowa): Provider's/Health Plan's Name: Recipient's Name: Provider's/Health Plan's Address: Address 1: Address 2: City: Z p: This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: April 1, 2014

Event Event Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121 Description of information to be used or disclosed is this request for psychotherapy notes? O Yes, then this is the only item you may request on this authorization. The most cubrate another authorization for other items below. WNo, then you may check as many items below as you need. Description: Date(s): Description: Description Date(s) Dalcis Ali PHI in medical record O Operative information Disboridelivery mm. D'Cath lab D'Special teathherapy Manager of Admission form OB mireling some Postpartum dev theet Dictation reports Distanted file @Physician orders Whythm Strips @Jatake/outtake M Nursing Information D'UB-52: Clinical Test W Fransfer forms O'Other all plit gin tile films,-x-rays, Mals, Medication Sheets DER Information CATEGEOR, etc. Other I acknowledge, and hereby consept to such, that the released information may contain alcohol, drug abuse, physicalic, HIV esting, HIV results or AIDS information. (Initial) If not applicable, check here. l understand that: 1. I may refuse to sign this authorization and that it is strictly voluntary. 2. If I do not sign this form, my health care and the payment for my health care will not be affected unlars stand omerwise. 3. I may revoke this authorization at any time in writing, but if I do; it will not have any affect on any ac ion taken prior to receiving the revocation: Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. I understand that I my attorney will receive copies of all records received through this authorization. 6. I, through my attorney, will get a copy of this form after I sign it, Section B 。 第一章,"我们是一个人,我们就是一个人,我们就是一个人,我们就是一个人,我们就是一个人,我们就是一个人,我们就是一个人,我们就是一个人,我们就是一个人,我们就 The purpose of the release of my seconds is for review by [medical care provider] for which I am granting my pulsarisation. THIS ANTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY IMEDICAL CARE PROPIDER OF THESE REPRESENTATIVES! OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm recents that an equested by the office. All medical records obtained pursuant to this authorization by imedical care provider; shall be copied by their officing an Bases-number of copy shall be furnished to my counsel factor ney and address), within five (5) days after the moords are obtained through medical this authorize the Section C: Signistures -I have read the above and authorize the disclosure of the protected health information as stated, Sionapura of Patient/Plan Member/Quardian/Patient/Plan Member Representative: Print Name of Patient/Plan Member's Representative Relationship to Fair-toPlan Memi er: Revised 3/2003

P (003/003

Page 22 of 33

Filed 02/18/14

Case 1:13-md-02419-RWZ, Document

Case 1:13-md-02419-RWZ Document 925-2 Filed 02/18/14 Page 23 of 33 AUTHORIZATION FOR TELEASE OF PROTECTED HEALTH INFOPMATION (PHI)

Section A: This section must b			orizations.		19.8. T. 18.	
Patient/Plan Member Name:			Birth Date:	KOD	Social Security No	1-3398
Provider's/Health Plan's Name		Recipient's Name:	/			
Provider's/Health Plan's Addr	ess:		pholdress.];			
			Address 2:			·
·			City:		State:	Zīp:
This authorization will expire of Date: April 1, 2014	on the following: (Fill in	the Date or the Event Event:	but not both.)		·
Purpose of disclosure: COM	IPLIANCE WITH	I.T.C.A	§ 29-26-121			·
*			of information to be.			
Is this request for psychotherap another authorization for other	oy notes? 🗆 Yes, items below. 🗹	then the	is is the only item you n you may check as n	ı may reguest on t iany items below	this authorization. You as you need.	
Description:	Date(s):	Descr	iption:	'Date(s)	Description:	Date(s)
MAIL PHI in medical record Chamission form Dictation reports Physician orders Intake/outtake Clinical Test Medication Sheets	_	D Ca D Sp D No D No D To	erative Information th lab ecial test/therapy ythm Strips rsing Information ansfer forms	<u>.</u>	Diabor/delivery sum Dib nursing assess Dibostpartum flow sh Ditemized bill: Dibi-92: Dither: all diagnosti films, x-rays, MRIs CAT scans, etc.	ect c
l acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. (Initial) If not applicable, check here.						
 I understand that: I may refuse to sign this authorization and that it is strictly voluntary. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. I understand that I my attorney will receive copies of all records received through this authorization. I, through my attorney, will get a copy of this form after I sign it. 						
Section B:						
The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.						
ection C: Signatures						
have read the above and author					1	
Sionature of Patien/Plan Memb	ocr/Guard <u>i</u> an/Pati	ent/Pla	n Member Represent	ative:	Date: 5/23/13	· · · · · · · · · · · · · · · · · · ·
rive Name of Patient/Plan Mer	hber's Represent	nive:	To Robe	CHI Louis	Relationship to Patien	dPlan Member:

May. 6. Case 1919 Mid-02419-RWZ Document 925-2 Filed 02/18/14 Page 24 of 33 9

		C. C	5 (3 (5)	SULED H	1.Px - 1	HOLLYMURGOLT F	CHD	
Section A: This section must	t be completed is	r all Authorizations						
Patient/Plan Member Neme	: Elizabeth A.	Pruist	Birth C	Bate: /3	/39	Social Security No.:	-53.19	
Persons or Organizations Aut	icrized to Disclos	e the information:	Persons or Organizations Authorized to Receive the Information;					
St. Thomas Fiospital Saint Thomas Network Saint Thomas Health Saint Thomas Medical Clinic	Stánt Ti	tomas Outpati	ont Neo	rosurgical Center, LEC	;			
This authorization will expire on the fellowing: (Fill in the Date or the Event but not both.) Date: 04/20/14 Event:								
Purpose of disclosure: COA	MPLIANCE WIT	TH T.C.A. § 29-26-1	21					
	Ocs	cription of informati	on to be t	ised or disclos	cd	, , , , , , , , , , , , , , , , , , ,		
fs this request for psychotherap authorization for other items be	oy notes? 🗅 Yes, Slow. 🗆 No. then	then this is the only i	tem you r any items	nay request or	i this au need.	therization. You must	submit another	
Description:	Date(s):	Description:		Date(s)		cription:	Date(s)	
X All PHI in medical record X Admission form X Dictation reports X Physician orders X Intake/outtake X Clinical Test X Medication Sheets		X Operative Inform X Cath lab X Special test/thera X Rhythm Strips X Nursing Informat X Transfer forms X ER Information	rby.		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	abor/delivery sum. B aursing assess estpartum flow sheet emized bill: B-92: ther: oil diagnostic ims. x-rays, MRls. I scans, etc.		
I acknowledge, and hereby con- results or AIDS information.	sent to such, that	the released informat 1) If not applicable, o	ion may a	contain alcoho	ી, હૈલાહું :	ibuse, psychiatric, HJV	testing, HIV	
I understand that: 1. I may refuse to sign this auding. 2. If I do not sign this form, my and it is form, my and it is form, my and it is may revoke this authorization. Further details may 4. If the requester or receiver it privacy regulations and may be 5. I understand that I my attorn 6. I, through my attorney, will a full of this Army photostatic copy of this Army in the full of this Army is the full of th	norization and that he health care and the inn at any time in the list of a nealth planed in the list of a health planed will receive coget a copy of this	t it is strictly volunta the payment for my b writing, but if I do, lotice of Privacy Pra n or health care prov pics of all records re form after I sign it,	ry. realth care is will no ctices, rider, the ceived the	e will not be a of have any eff refeased infor rough this aud	ect on a	may no longer be prote may actions taken prior	ta receiving the	
Section 8:								
THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES QUITSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are equested by this office. All gedient records obtained pursuant to this authorization by the above-listed equities shall be copied by their office and Bures-numbered copy shall be formished to my counsel Randall L. Kingards KINNARD, CLAYTON & BEVERIDGE; 127 Woodmunt confevered; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.								
Section C: Signatures	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	41				11 (1 (1 (1 (1 (1 (1 (1 (1 (1 (1 (1 (1 (
have read the above and author	rize the disclosure	of the protected hea	dir inform	nation us state	d.			
Signature of Patient/Plan Memb	oc/Guerdian/Patie	nt/Plus Alo nber Ron	างของเสน้	ve:	!Dute:	,		
Alon C. Noch	<u> anhance</u>					5-21-13		
rint Name of Potion/Plan Alon		livet			Rolar	ionship to Pottent/Plan	Members	
.esa C. Shadowhavzk			Dene	inter				

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations								
Patient/Plan Member Name:	J.W. Ragland		Birth D	ate:	//4]	Social Security No.:	-8512	
Persons or Organizations Authorized to Disclose the Information: St. Inomas Hospital Saint Thomas Network Saint Thomas Health Saint Thomas Medical Clinic				Persons or Organizations Authorized to Receive the Information: Saint Thomas Outpatient Neurosurgical Center, LLC				
This authorization will expire on the following: (Fill in the Date or the Event but not both.) Date: 04/20/14 Event:								
Purpose of disclosure: COM	IPLIANCE WIT	FH T.C.A. § 29-26-1	21	**************************************				
	Des	cription of informati	on to be	used or discle	sed			
Is this request for psychotherap authorization for other items be	y notes? □ Yes, t low. □ No, then	then this is the only i	tom you any item	may request of below as yo	on this au u need.	athorization. You must	submit another	
Description:	Date(s):	Description:		Date(s)	Des	scription:	Date(s)	
X All PHI in medical record X Admission form X Dictation reports X Physician orders X Intake/outtake X Clinical Test X Medication Sheets		X Operative Information X Cath lab X Special test/therapy X Rhythm Strips X Nursing Information X Transfer forms X ER Information			D C O P X I X U X C f CA	abor/delivery sum. OB nursing assess ostpartum flow sheet temized bill: JB-92: Other: all diagnostic ilms, x-rays, MRIs, T scans, etc. Other:		
I acknowledge, and hereby coar results or AIDS information.	sent to such, that	the released informa l) If not applicable,	tion may check he	contain alcol	iol, drug	abuse, psychiatric, HIV	testing, HIV	
I understand that: 1. I may refuse to sign this authorization and that it is strictly voluntary, 2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 5. I understand that I my attorney will receive copies of all records received through this authorization. 6. I, through my attorney, will get a copy of this form after I sign it. 7. A photostatic copy of this Authorization is to be considered as effective as the original.								
Section B:					`			
THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L, Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.								
Section C: Signatures								
I have read the above and authorize the disclosure of the protected health information as stated.								
Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: Date:								
Recly Raclado 3-22-2013							13	
Print Name of Vatient/Plan Me	iber's Represents	itive:	300mm	######################################	Rel	ationship to Patient/Plan	ı Member:	
Becky Ragland					Wif	Č		

Wife

Colette Rybinski

<u>AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION</u> <u>PURSUANT TO HIPAA C.F.R. 164.512</u>

I authorize the use/disclosure of health information as described below.

1.	Person(s) or class of persons, medical provider or other entity or person authorized to disclose the information:
2.	Person(s) or class of persons or provider, company or entity to whom the information may be disclosed: ST. THOMAS OUTPATIENT NEUROSURGICAL CENTER, LLC
3.	I understand that this may include information relating to acquired immunodeficiency syndrome (AIDS) or infection with HIV (Human Immunodeficiency Virus), psychiatric care, treatment for alcohol and/or drug abuse, and/or genetic testing.
4.	Description of information to be disclosed: Medical records and reports, patient information and history forms, x-rays, x-ray report, pathology, pathology reports, insurance records, health care providers' reports and consultations, prescriptions, off-work slips, therapy records, lab reports, notes, tests and billing records and statements.
5.	The information will be used/disclosed for the following purposes: For medical providers and any other person or entity to obtain medical records for the purpose of determining what happened to John Charles Sawyers and what persons, manufacturers, distributors, purchasers or entities are responsible for causing injury to Mr. Sawyers and for any other lawful purpose.
6.	I understand that the health information described above may be redisclosed and no longer protected by federal and state privacy regulations.
7.	I understand that my healthcare or payment for healthcare will not be affected if I refuse to sign this authorization.
8.	In consideration of the release of information by, in accordance with this request, I hereby release, its agents, servants, and employees from any and all claims, demands, or liability of any kind, which might arise of or from the release of such information and the effects thereof.
notice address disclosi	stand that I have the right to revoke this authorization in writing at any time by sending written of revocation to the person(s), class of persons or provider, company or entity at the above. I understand my revocation of this authorization will not be effective as to uses and/or uses of any information that the person(s) and/or organization have previously provided. A this signed release shall be deemed as effective as if it were the original.
This au	thorization shall expire two years from the date of its execution.
TOHE	DOB: 1949 S.S. NO: 11-3457
DATE:	Lo-10-13

AUTHURIZATION			KOTEFTED DE					
Section Cases 1-13-mod	02419e.BWZ	ADA	Gument 925-2	Filed 02/18	/14 F	Page 28 of 3	3	
Patient/Plan Member Name:	Hinsun	\	Birth Date:,	Birth Date:, Social Security No.				
Provider's/Health Plan's Nam	e:		Recipient's Name:					
Provider's/Health Plan's Address:			Address 1.~ .					
			City:		St	ate:	Zip:	
This authorization will expire Date: April 1, 2014	on the following:	(Fill in	the Date or the Event Event:	but not both.)				
Purpose of disclosure: CON	MPLIANCE WITH	H T.C.A	§ 29-26-121					
•	Desc	ription	of information to be	used or disclosed				
Is this request for psychotheral another authorization for other	oy notes? 🗆 Yes, items below. Ø	then th No, the	is is the only item you n you may check as n	u may request on t	this authors	orization. You mu	ist submit	
Description:	Date(s):	Descr	iption:	Date(s)	Descrip	otion:	Date(s)	
		Call Spe Co Rh O Rh O Nu	erative Information th lab ecial test/therapy ythm Strips rsing Information ansfer forms Information		☐ Labor/deliver☐ ☐ OB nursing as ☐ Postpartum fle ☐ Itemized bill: ☐ UB-92: ☐ Other: all diag films, x-rays, CAT scans, et ☐ Other:		nostic MRIs,	
I acknowledge, and hereby con results or AIDS information.	sent to such, that	the rele	eased information ma ot applicable, check h	y contain alcohol, iere. []	drug abı	ise, psychiatric, H	IV testing, HIV	
1 understand that: 1. I may refuse to sign this aut. 2. If I do not sign this form, m. 3. I may revoke this authorizat receiving the revocation. Fi. 4. If the requester or receiver is federal privacy regulations at. 5. I understand that I my attorn. 6. I, through my attorney, will	y health care and ion at any time in arther details may snot a health plan and may be rediscued will receive contains.	the pay writing be found or head closed.	ment for my health can be to find the long of Pind in the Notice of Pind in the care provider, the fall records received	ot have any affect rivacy Practices. released information	on any a	no longer be prot		
Section B:								
The purpose of the relean AUTHORIZATION DOES NOT REPRESENTATIVES OUTSID office. All medical records obtaine copy shall be furnished to my country.	E THE PRESENCE	O DISC CE OF N	USS THESE MATTE. 17 ATTORNEYS. YO	ou may furnish this in convider shall be convided to the convidence of the convidenc	law firm r opied by t	ecords that are reque heir office and a Ba	ested by this tes-numbered	
Section C: Signatureş								
I have read the above and autho	orize the disclosur	e of the	protected health info	ormation as stated	ļ.			
Rionature of Patient/Plan Memb	per/Guardjan/Pati	en VP lai	n Member Represent	ative:	Date:	17/13		
Print Name of Parient/Plan Mer	rint Name of Patient/Plan Member's Representative: Relationship to Patient/Plan Member:							

Case 1:13-md-02419-RWZ Document 925-2 Filed 02/18/14 Page 29 of 33

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient	Name <u>Bar</u>	bara A. Taylor				
Date of	Birth	-1949		Social Secu	rity Number	148
1.	I authorize tl	ne use or disclosure o	f the above name	ed individual's	health information as	described below:
2.		g individual or organiz roviders and treaters.		ed to make the	e disclosure: all medi	cal sources,
	Address:					
3.	appropriate) physicia discharged consulta	nd amount of inform an/nurse assessment ge summary ation reports	medicatio	n list	history and physical	
	transmitted	I that the informatio disease, acquired im ay also include inforr drug abuse.	munodeficiency	syndrome (A	IDS), or human imm	unodeficiency virus
		tion may be disclosed Ithcare providers and				on: all medical
	for the purpo	se of litigation and to	comply with Ten	n. Code Ann.	§ 29-26-121.	
	authorization management that has alre apply to my i my policy. If year. I furthe	I have the right to I must do so in we department and requested been released in the surance company we I fail to specify an exer authorize the abover this document, said	vriting and presouesting party. It is response to the law proving ration date, ever referenced productions.	ent my writte understand the is authorization in authorization in authorization in authorization in accept or condition in accept or accept in acc	en revocation to the e revocation will not a con. I understand the rer with the right to con, this authorization opt a copy of this Authorization.	health information apply to information revocation will not ontest a claim under will expire in one (1) norization instead of
	authorization the informati information c	that authorizing the d . I need not sign this on to be used or dis- arries with it the pote federal confidentiality	form in order to closed, as providential for an unau	assure treatn ded in CFR 1	nent. I understand I r 64.524. I understan	nay inspect or copy d any disclosure of
į	<i>Bas La</i> Signature of	Mo Q. Jo. Patient or Legal Repr	stor sentative	-م)	-D-13 Date	
- -	If Signed by I	_egal Representative,	Relationship to	Patient		

	lop.	or all Authr	Birth Da		1 10	Carlotte State of the Contract				
Blake JAY Provider's/Health Plan's No	los_		Bîπh Dτ			Social Security N				
	ime:	Blake TAYLOR			Birth Day					
Provider's/Health Plan's Ad		Provider's/Health Plan's Name:								
	Provider's/Health Plan's Address:			Address)						
			Address 2:	74.4		· · · · · · · · · · · · · · · · · · ·	**************************************			
			City:	THE RESERVE OF THE PERSON OF T		States	Zip:			
This authorization will expire Date: April 1, 2014	e on the following	g: (Fill in tl	he Date or the Even Event:	t but not both.)		, , , , , , , , , , , , , , , , , , ,	•			
Purpose of disclosure: CC	MPLIANCE WI	TH T.C.A.	§ 29-26-121							
	De	scription o	finformation to be	used or disclose	đ					
Is this request for psychothers another authorization for othe	apy notes? Si Ye or items below. E	s, then this I No, then	is the only item yo you may check as n	u may request or nany items belov	this su v styou	thorization. You n	nust submit			
Description:	Date(s):	Descrip	ition;	'Datc(s)	Desc	ription:	Date(s)			
☐ All PHI in medical record ☐ Admission form ☐ Dictation reports ☐ Physician orders ☐ Intake/outtake ☐ Clinical Test ☐ Medication Sheets		☐ Cath☐ Spec☐ Rhyti☐ Nurs:☐ Trans	ative Information lab ial test/therapy hm Strips ing Information sfer forms		0 00 0 00 0 00 0 00 0 00	abor/delivery sum. B nursing assess ostpartum flow sheemized bill: B-92: ther. all diagnostic ms, x-rays, MRIs, AT scans, etc. ther:	26			
I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. (thitial) If not applicable, cheek here.							HIV testing, HIV			
1 understand that: 1. I may refuse to sign this authorization and that it is strictly voluntary. 2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 5. I understand that I my attorney will receive eopies of all records received through this authorization. 6. I, through my attorney, will get a copy of this form after I sign it. Section B.										
The purpose of the release ITHORIZATION DOES NOT I EPRESENTATIVES! OUTSIDE fice. All medical records obtained by shall be furnished to my course	PERMIT YOU TO ETHE PRESENC DUISUANT to this at	ODISCUSS EOFMY whorization	THESE MATTER ATTORNEYS. You by Imedical case of	S WITH ANY IM may furnish this l avided thall be so	IEDICA law (irm onied by	L CARE PROVIDE records that are requ their office and a Ba	CR OR THEIR			
ction C: Signatures	· · · · · · · · · · · · · · · · · · ·	· · · · · · · · · · · · · · · · · · ·		YY\$,34767 3547,8374,036		Mary Control of the Section of	Company Control			
ave read the above and author										
Dale la De			ember Representati	ive;	Date:	123/13				
nt Name of Patient/Plan Memi	ber's Representation	tive: UVI				onship to Patient/P	lan Member:			

CONTRACT ELECTRICATION A RANGES AUTHORIZATION FOR "TLEASE OF PROTECTED HEALTH INFOPMATION (PHI) Section A: This section must be completed for all Authorizations Birth Date: Patieny#Hap Member Name: Provider's/Health Plan's Name Recipient's Name: Provider's/Health Flan's Address: Address.it Address 2: Zio: States City: This authorization will expire on the following (Fill in the Date or the Event but not both.) Date: April 1, 2014 Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121 Description of information to be used or disclosed Is this request for psychotherapy notes? DYes, then this it the only item you may request on this authorization. You must submit another authorization for other items below. If No, then you may check us many items below as you need. Date(s) Description: Date(s) Date(s): Description: Description: QL abor/delivery sum. SOperative Information All PHI in medical record GOB nursing assess D'Admission form WCath lab DPostpartum flow sheet O'Special test/therapy @Dictation reports Ulternized bill: Withythm Strips A Physician orders DX (18-92: ☑ jnteke/outtake Marsing Information Q'Ôther, all diagnostic W Fransfer forms Clinical Test films, x-rays, MRIs, WER Information E/Medication Sheets CAT scans, etc. Other: Lacknowledge, and hereby conserved such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. (Initial) If not applicable, check here. CI Lunderstand that: 1. I may refuse to sign this authorization and that it is strictly voluntary. 2. If I do not sign this form, my health one and the payment for my health care will not be affected unless stated otherwise. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Netice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 5. I understand that I my attorney will receive copies of all recents received through this authorization. 6. I, through my attorney, will get a copy of this form after I sign it. Section B: The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY IMEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES LOUTSIDE THE PRESENCE OF MY ATTORNEYS. You may formish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by justified care provider; shall be copied by their office and a flates-numbered copy shall be furnished to my counses farterney and address), within live (5) days after the records are obtained through the use of this authorization. principles ____

Print Name of Pailant/Plan Menyode is Remescriptive:

uthorize the disclosure of the processed health information as stated.

Merober/Covardjan/Patient/Plan Member Representative:

hp to Patient/Plan Member:

Revised 3/2003

I have read th

Patient/Plan Member Name:	Birth Date:	178	Social Security	No. (optional): -03/3				
Provider's/Health Plan's Nar	ne:	Recipient's Na	Recipient's Name:					
Provider's/Health Plan's Add	} Address.1:							
	Address 2:							
		City:		State:	Zip:			
This authorization will expire Date: April 1, 2014	on the following	g: (Fill in the Date or the l Event:	Event but not both.					
Purpose of disclosure: CO	MPLIANCE WI	TH T.C.A. § 29-26-121						
•		escription of information t			44,444			
s this request for psychothera mother authorization for othe	npy notes? 🗆 Ye r items below. [s, then this is the only ited. No, then you may check	m you may request as many items bel	on this authorization. Yo ow as you need.	u must submit			
Description:	Date(s):	Description:	Date(s)	Description	Date(s)			
All PHI in medical record Admission form Dictation reports Physician orders Intake/outtake Clinical Test Medication Sheets		☐ Operative Informat ☐ Cath lab ☐ Special test/therapy ☐ Rhythm Strips ☐ Nursing Informatio ☐ Fransfer forms ☐ ER Information		DLabor/delivery su OB nursing assess Postpartum flow s Itemized bill: UB-92: Other: all diagnos films, x-rays, MR CAT scans, etc. Other:	s sheet stic			
acknowledge, and hereby consults or AIDS information.	nsent to such, th	tial) If not applicable, ch	eck here.	mor, drug aduse, psychiau				
understand that: I may refuse to sign this au If I do not sign this form, n I may revoke this authoriza receiving the revocation. F If the requester or receiver federal privacy regulations I understand that I my attor I, through my attorney, will ection B:	ny health care an tion at any time further details mais not a health pl and may be redi ney will receive	d the payment for my hea in writing, but if I do, it vay be found in the Notice an or health care provide sclosed. copies of all records rece	Ith care will not be vill not have any af of Privacy Practice r, the released infor	es. mation may no longer be	prior to			
	PERMIT YOU DE THE PRESENT TO This	TO DISCUSS THESE MANCE OF MY ATTORNEY: authorization by Imedical of	TTERS WITH AN) S. You may furnish to the care provider shall lead to the care of the care	his law firm records that are oc copied by their office and	requested by this a Bates-numbered			
ction C: Signatureş								
	orize the disclos	ure of the protected healt	h information as st	ated.				
ave read the above and auth	Signature, of Patient/Plan Member/Guardian/Patient/Plan Member Representative: Date: 5/23/13							
mature, of PapienUPlan Mem	amt am	gienorian wiemoer Repre		13/20/12				
mature, of PapienUPlan Mem	ans			Relationship to Patie	ent/Plan Member:			

May. 2. 2013 2:22PM No. 1916 P. 6// Case 1:13-md-02419-RWZ Document 925-2 Filed 02/18/14 Page 33 of 33

LIMITED AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION OR RECORDS

By signing below, I hereby disclose certain information (request and he "Informatio	authorize the Health Care Provider identified below to on") as provided in this Authorization.
4.	Informatio	on To Be Used Or Disclosed
Patient Name:Earline T. Willia	ns	Patient Identifier: DOB: 1940
Description of Information: Any a possession, custody or control, in prognoses, records of treatment physicians, electrocardiograms, x records, pathological reports, slic account, incident reports, birth cer	and all medical liciuding, but not and medication ray films and rees and specime tificates, death coustody or confination.	Information and records, or true and correct copies thereof, in your limited to, medical histories, records, reports, summaries, diagnosis, ordered and/or given, entries, letters or correspondence to other eports, ultrasounds, diagnostic imaging studies, laboratory data and ens, prescription records, insurance records, bills or statements of certificates and all other written or graphic data prepared, kept, made rol and summaries of injuries, treatment and prognosis, if requested, ON DOES NOT AUTHORIZE VERBAL COMMUNICATIONS WITH TION.
Persons (r Organizations	s Authorized To Disclose The Information
Health Care Provider. Saint Ti Corporation: St. Thomas Hospital	nomas Outpatier John Weeks C	nt Neurosurgical Center, LLC; Howell Allen Clinic A Professional Culclasure, M.D.; Debra V. Schamberg, R.N.
and the state of the second of the company of	of this Authorizati rization. The He	nployees and agents to disclose the Information as provided in this ion is to be considered as effective as the original. I understand that ealth Care Provider will not condition treatment, payment, enrollment orization.
	urgical Center, rd, M.D., 2011 l 2013.	LLC or any representative, attorney or investigator from said Murphy Ave, Ste 301, Nashville, TN 37203-2023 or Floor 9, 4230 Requested Use or Disclosure
Lego	<u>)</u>	
		evocation of This Authorization
	Authorization at a	any time prior to the expiration date or event, but that my revocation lth Care Provider, its employees or agents before they received my ation, I must send written notice to the Health Care Provider at the
I understand that I may see and cop subject to re-disclosure by the recipi Signature (Patient)	y the Information ant and may no I Date	n if I ask for it. I understand that any Information released may be longer be protected by federal or state privacy law or regulations.
Signature (Witness)		Relationship to Patient